and in some cases treatment will have to be instituted before people are dispersed throughout the country. This is a formidable task, but one which should be undertaken if the N.H.S. is not to be overloaded with work as the result of imported and transmitted illness.—I am, etc.,

C. R. SALKELD
Bournemouth, Hants

Aetiology of Variocity

Sir,—Any proposition from Mr. Denis Burkitt (3 June, p. 556) must be treated with respect, but the thesis that haemorrhoids and varicose veins have a similar causation from bowel dysfunction seems too facile. I submit a list of questions which are provoked by it.

(1) Can we assume that people in these two common conditions would provide for? There has been no notable concomitance in my own experience.

(2) Can this theory explain why varicose veins are so much commoner in women? Does it explain the well-known aggravation of varicose veins during pregnancy (indeed, very early in pregnancy) or the temporary aggravation which many women experience (at least of symptoms) with menstruation?

(3) Can this account for the often quite irregular (and sometimes bizarre) distribution of varicose veins? It is not at all uncommon for them to be quite marked on one lower limb and not (or scarcely) in evidence at all on the other; while odd patterns of tortuosity and dilatation of the superficial veins of the lower limbs are common-place.

My own belief is that the hereditary influence is the most important of perhaps several factors responsible for varicose veins—I, at least, with the well-known familial incidence. They are second cousins to angiomata, of which frank examples of segmental distribution are the extreme and indisputably inborn venous and arteriovenous anomalies. Others, I submit, are a more or less chiefly an inherited vascular "weakness" or anomaly of development of a lesser degree. This may well be an oversimplification itself, and a begging of the question. But to accept varicose veins as due to constipation seems almost too ceductive.—I am, etc.,

Robert S. Lawson
Melbourne, Victoria, Australia

Effects of Dietary Fibre

Sir,—With regard to the letter by Sir Charles Dodds and others (19 August, p. 472) I showed in my own letter (13 May, p. 408) how little importance I attached to the change in flour milling in 1880, compared with the vastly increasing sugar consumption at that period; and with respect to the incidence of varicose veins in Africa, Mr. P. Burkitt's paper (3 June, p. 556) deals comprehensively with this very subject. But as regards Sir Charles's pejorative remarks about the taking of natural, unprocessed bran I have in the above letter written of my 30-year experience with this material. He speaks of the occasional case who complains after this natural restitution, but he does not speak of the scores who are better for the name of whoever introduces them to it.—I am, etc.,

T. L. CLEAVE
Paremah, Hants

Chloramphenicol Resistance in Typhoid

Sir,—Your leading article (5 August, p. 306) in the British Medical Journal prompts me to report my experiences in treating 36 cases of typhoid in Malawi between 1968 and 1970.

The prerequisites for chloramphenicol resistance mentioned in this paper by Mr. H. R. Smith (5 August, p. 329) apply in that typhoid was endemic in the district and chloramphenicol was extremely widely used. Thirty-three cases were in local Africans and three were in British expatriates. All of the expatriates had a good response to chloramphenicol. It is interesting to note that only one of the three had received a recent T.A.B. vaccination.

Of the 33 was challenged showed no clinical response to chloramphenicol, though two of them showed in vitro sensitivities to it on blood culture. The third case showed only partial in vitro sensitivity to chloramphenicol. As ampicillin was not obtainable readily all three resistant cases were treated with tetracycline, to which the organism showed laboratory sensitivity, and they showed an excellent clinical response. Of the remaining seven cases seven were treated with tetracycline before a definite diagnosis of typhoid had been made and two had such a good response that chloramphenicol did not have to be substituted. In the former four responded to chloramphenicol after failure of tetracycline therapy. A single case, originally diagnosed as a urinary infection, responded to sulphadimidine and did not require chloramphenicol.

Ampicillin was used only once—on a child who had been treated originally with chloramphenicol and who continued to pass Salmonella typhi in the urine after cessation of treatment. Urine cultures after ampicillin therapy were negative.

In summary, out of 36 cases of typhoid three responded to tetracycline after failure of chloramphenicol therapy and two required ampicillin. Five cases failed to respond to tetracycline and required chloramphenicol.—I am, etc.,

John F. Calder
Royal Infirmary, Glasgow

Transmission of Malaria

Sir,—"Madras Club, December 3rd 1889. I am about to take up mosquito collecting. Since Major Donald Ross's investigations into the 'malarial mosquito' the whole Indian medical faculty is agog with this subject. But medical men, although many are keen enough to be specialists, are very uneven, and also there is very little. Some have button-holed the keen ones, told them to place materials at my disposal and promised to collect for them. As I visit all climates, including feverish and healthy ones, I am in far the best position to collect. Perhaps too may line will doing and reffer me more fitted for the necessary discrimination and work with me?

This is an extract from the journals which my father kept from the time he went out to India as a government botanist in 1898 until he retired from his post as agricultural adviser (1847). He used to spend more than half of each year on tour in remote villages studying the crops and diseases and methods of agriculture, and this involved the collection of numerous biological specimens. He was also an expert entomologist, and collected numerous specimens of mosquito, which he dispatched to the headquarters at Secunderabad; some of them he had captured in the act of biting himself. Like any other travelling English official in India, he suffered frequently from malaria: but he brushed it off as "an attack of fever, I increased my usual dose of quinine."—I am, etc.,

Geoffrey Barber
Dunmow, Essex

E.T.N. Advances

Sir,—Dr. R. Hinchcliffe (12 August, p. 419) and Dr. L. Fisch (19 August, p. 471) have both taken issue with my criticism in a recent review (22 July, p. 243) of their failure to refer to electrocochleography. In fact, I was not criticizing but rather excusing them for it.

To take the latter first, there are many points in Dr. Fisch's letter with which I am in total agreement and I am pleased that your columns have given him an opportunity to make them. In particular, I would be the last to "hope that a technical opinion which has been taken on behalf of the profession would be under pressure to reconsider it" when he wrote "I think it is a fact that in many of the places where I spent my time I may still have omitted electrocochleography." Dr. Hinchcliffe, in effect, defends the omission of electrocochleography on the ground that it is one of the "not yet established clinical procedures." Of course it is not, but an established procedure is not the same thing as a trend, and whatever else it may prove ultimately to be there is no doubt that today electrocochleography is one of the more interesting trends in otologyngology. And that, after all, is the title of the book.—I am, etc.,

John Ballantyne
Royal Free Hospital, London WC1

Hands off Postgraduate Centres

Sir,—It seems now to have become established history that the Christ Church conference "started what was soon to become an explosion of activity, as your leading article states (3 June, p. 547). Hardly ever was any reference made to the fact that